

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

05408

Reg. Dist. No.

5417

1. PLACE OF DEATH o. COUNTY <u>Calvert Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Charles</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince, Fredrick.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Waldorf</u>			
c. LENGTH OF STAY IN 1b <u>pya. 5 month.</u>				d. STREET ADDRESS <u>08x-2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Calvert Nursing Home.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Robert.</u> First <u>R.</u> Middle <u>Anderson.</u> Last			4. DATE OF DEATH Month <u>May</u> Day <u>7</u> Year <u>1959</u>				
5. SEX <u>M</u>	6. COLOR OR RACE <u>Cau</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 10, 1890</u>		9. AGE (In years last birthday) <u>68</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Boiler Maker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Machinery</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert J Anderson</u>			14. MOTHER'S MAIDEN NAME <u>UNK</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Bill Hamilton, Waldorf, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia.</u> <u>493X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on <u>May 6</u> , 19 <u>59</u> , and that death occurred at <u>6:40</u> A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>A W Ward</u> M.D.				PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-9-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St Pauls</u>		22d. LOCATION (City, town, or county) (State) <u>Waldorf, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>The Hunt & Funeral Home, Waldorf, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>MAY 11 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanna</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05409

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Georges</u> c. LENGTH OF STAY IN 1b <u>XXXXXX</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Calvert Co. Hospital</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Calvert</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Breezy Point, Willows, Md.</u> d. STREET ADDRESS <u>XXXXXX</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Scarp Lee Boswell</u> First Middle Last		4. DATE OF DEATH Month <u>5</u> Day <u>21</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OF RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/3 '96</u>
9. AGE (In years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u> </u>	
13. FATHER'S NAME <u>George Boswell</u>		14. MOTHER'S MAIDEN NAME <u>Martha Thompson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Ethel M. Boswell</u>		18. BIRTHPLACE (State or foreign country) <u>Breezy Point Willows, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>260X Diabetic Coma</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Drift away at time of death, who was his Dr.</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>		20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o. m. <u> </u> p. m. <u> </u> 19 <u> </u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>		21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .	
ACTUAL SIGNATURE <u>H. W. Ward</u> EXAMINER'S NAME (Type) <u>Dr. Hugh W. Ward</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/23/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Prince Georges Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Hines Company - Washington</u>		24a. REC'D BY REGISTRAR <u> </u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

TO THE HONORABLE SENATE OF THE UNITED STATES
IN SENATE, FEBRUARY 1, 1895.
REPORT
OF THE
COMMISSIONERS OF THE LAND OFFICE,
IN RESPONSE TO A RESOLUTION PASSED BY THE SENATE
JANUARY 1, 1894.
WASHINGTON:
GOVERNMENT PRINTING OFFICE:
1895.

5419 CERTIFICATE OF DEATH

Reg. Dist. No. 05410

1. PLACE OF DEATH o. COUNTY <u>Calvert</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Calvert</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick 22 hrs</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Huntingtown, Md</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Calvert County Hospital</u>				d. STREET ADDRESS <u>Huntingtown, Md</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Brown</u>				4. DATE OF DEATH Month Day Year <u>May 12 1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 12, 1959</u>	
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. <u>22</u>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Brown</u>				14. MOTHER'S MARDEN NAME <u>Lva Lee Smith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>Lva Lee Smith - Huntingtown, Md</u>		17. INFORMANT Address <u>Lva Lee Smith - Huntingtown, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Undetermined -</u> <u>773.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Respiratory failure - Child apnea</u> DUE TO (c) <u>Dehydration, jaundice / virus?</u>							INTERVAL BETWEEN ONSET AND DEATH <u>22 hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>5/18</u> , 19 <u>58</u> , to <u>5-13</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>May 13</u> , 19 <u>59</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R. E. Villacres</u>				ADDRESS (Street, city or town, state) <u>St. Remond</u>			
PHYSICIAN'S NAME (Type) <u>R. E. Villacres</u>				DATE SIGNED <u>5/18</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>5-14, 59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Johns</u>		22d. LOCATION (City, town, or county) (State) <u>lower marlboro Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>P. E. Sewell, Prince Frederick</u>				24a. REC'D BY REGISTRAR DATE <u>MAY 20 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur & Klaus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2064181XV3

CERTIFICATE OF DEATH

2418

10440

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male	
3. AGE 65		4. DATE OF BIRTH 1880	
5. PLACE OF BIRTH BALTIMORE, MARYLAND		6. OCCUPATION Carpenter	
7. MARITAL STATUS Married		8. EDUCATION High School	
9. RELIGION Roman Catholic		10. RACE White	
11. DATE OF DEATH 1945		12. TIME OF DEATH 10:30 AM	
13. PLACE OF DEATH Home		14. CAUSE OF DEATH Heart Disease	
15. DISEASE OR INJURY Coronary Artery Disease		16. PREVIOUS ILLNESS Hypertension	
17. MEDICAL ATTENDANCE Dr. J. H. Smith		18. SURVIVAL No	
19. SIGNATURE OF DECEASED (None)		20. SIGNATURE OF WITNESSES J. H. Smith, M.D.	
21. SIGNATURE OF REGISTRAR J. H. Smith		22. SIGNATURE OF CLERK J. H. Smith	



1. This certificate is to be filled out by the physician or other qualified person who attended the deceased during his last illness. It should be filled out as soon as possible after death, and should be filed in the office of the Registrar of Deaths, Baltimore, Maryland, within 24 hours of the death.

2. The cause of death should be stated in as much detail as possible, and should be based on the findings of the physician or other qualified person who attended the deceased during his last illness.

3. The date of death should be stated in full, including the day, month, and year.

4. The time of death should be stated in full, including the hour, minute, and second.

5. The place of death should be stated in full, including the street, city, county, and state.

6. The occupation of the deceased should be stated in full, including the name of the employer and the nature of the work.

7. The marital status of the deceased should be stated in full, including the name of the spouse and the date of marriage.

8. The education of the deceased should be stated in full, including the name of the school and the degree or diploma received.

9. The religion of the deceased should be stated in full, including the name of the church and the denomination.

10. The race of the deceased should be stated in full, including the name of the race and the color of the skin.

11. The disease or injury should be stated in full, including the name of the disease or injury and the part of the body affected.

12. The previous illness should be stated in full, including the name of the illness and the date of onset.

13. The medical attendance should be stated in full, including the name of the physician or other qualified person who attended the deceased during his last illness.

14. The survival should be stated in full, including the name of the person who survived and the date of survival.

15. The signature of the deceased should be stated in full, including the name of the deceased and the date of signature.

16. The signature of the witnesses should be stated in full, including the name of the witnesses and the date of signature.

17. The signature of the registrar should be stated in full, including the name of the registrar and the date of signature.

18. The signature of the clerk should be stated in full, including the name of the clerk and the date of signature.

CERTIFICATE OF DEATH

Reg. Dist. No.

05411

5420

1. PLACE OF DEATH a. COUNTY <u>Cabaret</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Cabaret</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lusby</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lusby</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>f</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Charles F. Catterton</u>				4. DATE OF DEATH Month Day Year <u>May 9 1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 28, 1867</u>	9. AGE (In years last birthday) <u>92</u> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Cabaret Co., Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Charles B. Catterton</u>				14. MOTHER'S MAIDEN NAME <u>Sarah A. France</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>James W. Catterton - Lusby, Md</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion -</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cholesterol in Arteries</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 1918</u> , to <u>May 9, 1959</u> , that I last saw the deceased alive on <u>May 9, 1959</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R. de Villarreal</u> M.D.				ADDRESS (Street, city or town, state) <u>5 Leonard St.</u> DATE SIGNED <u>5/11/59</u>			
PHYSICIAN'S NAME (Type) <u>R. de VILLARREAL</u>				ST. LEONARD S			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 12, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Paul's Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Lusby - Cabaret Co - Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. A. Wadsworth & Son - Mutual, Md</u> ADDRESS				24a. REC'D BY REGISTRAR DATE <u>MAY 13 1959</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed **within 24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item 7 FilmG242 5-18-59 et

5421 CERTIFICATE OF DEATH

05412

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>CALVERT</u>		MARYLAND		STATE <u>MD.</u>		COUNTY <u>ST. Mary's</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>PRINCE FREDERICK</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Mechanicsville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>CALVERT Nursing Home</u>				STREET ADDRESS (If rural give location) <u>Rural</u> <u>18x-2</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Thomas B. DAVIS</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>MAY 9 1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>5-12-1876</u>	9. AGE last birthday <u>88</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Gen. Store</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Wm J. Davis</u>				14. MOTHER'S MAIDEN NAME <u>Mary Turner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Hosp. Records.</u>		
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
420.1 IMMEDIATE CAUSE (A) <u>CORONARY OCCLUSION</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 MINUTES</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>HYPERTENSIVE C. V. Disease.</u>						<u>3 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>PROSTATISM</u>						<u>?</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION			19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec.</u> , 19 <u>57</u> , to <u>May 7</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>April 24</u> , 19 <u>59</u> , and that death occurred at <u> </u> M, from the causes and on the date stated above. SIGNATURE <u>[Signature]</u> M.D. <u>Prince Frederick</u> ADDRESS (Street, city, town, state) <u>579/57</u> DATE SIGNED <u>5/9/59</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>5-12-59</u>		NAME OF CEMETERY OR CREMATORY <u>All Faith</u>		LOCATION (City, town, or county) (State) <u>Charlotte Hall Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>P. B. Robinson</u>		ADDRESS <u>Leonardtown Md.</u>	
DATE <u>MAY 12 '59</u>							

CERTIFICATE OF DEATH

02119

DATE OF DEATH

PLACE WHERE DEATH OCCURRED

SEX

RACE

EDUCATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

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INSTRUCTIONS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5422 CERTIFICATE OF DEATH

Reg. Dist. No.

05413

1. PLACE OF DEATH a. COUNTY <u>Cabret</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Ind</u> b. COUNTY <u>Cabret</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Huntingtown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Huntingtown</u>			
c. LENGTH OF STAY IN 1b <u>3 yrs</u>				d. STREET ADDRESS <u>Frank's Rest Home</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>KATHERINE W. DORSEY</u>				4. DATE OF DEATH Month Day Year <u>May 2 1959</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 25, 1871</u>	
9. AGE (In years last birthday) <u>87</u> yrs.		10. AGE (In years last birthday) <u>87</u> yrs.		11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Finance Officer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Welfare Dept</u>			
13. FATHER'S NAME <u>Nathan Ward</u>				14. MOTHER'S MAIDEN NAME <u>Belle Wilson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT Address <u>Frank Dorsey - Huntingtown, Ind</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion.</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____				20g. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>1-10</u> , 19 <u>58</u> , to <u>2 May</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>2 May</u> , 19 <u>59</u> , and that death occurred at <u>11 P. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>G. J. Weems</u> M.D. <u>Huntingtown, Ind</u> <u>5/4/59</u>				ADDRESS (Street, city or town, state) DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>G. J. WEEMS</u> <u>HUNTINGTOWN, MD.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>May 5, 1959</u>		<u>Emmanuel Church Cem. Plum Point - Cabret Co - Ind.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>A. D. Harkness & Son - Mutual, Ind.</u>				24a. REC'D BY REGISTRAR DATE <u>MAY 6 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5423 CERTIFICATE OF DEATH

Reg. Dist. No. 05414

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Calvert</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Dowell</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Calvert County Hospital</u>		d. STREET ADDRESS <u></u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Gross</u>		4. DATE OF DEATH Month Day Year <u>5 11 1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/12/59</u>
9. AGE (In years last birthday) <u>8</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>md</u>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>P</u>		14. MOTHER'S MAIDEN NAME <u>Lorraine Gross</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Lorraine Gross</u>		Address <u>Dowell, md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> <u>776x</u> DUE TO <u>(No prenatal care)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 11</u> , 19 <u>59</u> , to <u>May 11</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>5/11</u> , 19 <u>59</u> , and that death occurred at <u>4:30 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R de Vicca</u>		ADDRESS (Street, city or town, state) <u>St Leonard</u>	
PHYSICIAN'S NAME (Type) <u>R de Vicca</u>		DATE SIGNED <u>5/12/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>5-13-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Johns</u>	22d. LOCATION (City, town, or county) (State) <u>hwy 1 Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>P. E. Sewell, Prince Fred,</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 14 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5424

CERTIFICATE OF DEATH

05415

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Calvert</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St. Leonards Md</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St. Leonards Md</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Jane</u> Last <u>Gross</u>				4. DATE OF DEATH Month <u>5</u> Day <u>2</u> Year <u>1959</u>			
5. SEX <u>F.</u>		6. COLOR OR RACE <u>C.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 7, 1881</u>	
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Charles Hooks</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Murnay</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>George Gross</u>		Address <u>St. Leonards Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cornary occlusion in</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral arteriosclerosis</u> DUE TO (c) <u>(Sudden death)</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>St. Leonards Md</u> <u>5/2</u>							
ACTUAL SIGNATURE <u>R. Devillac</u>				M.D. <u>St. Leonards Md</u>			
PHYSICIAN'S NAME (Type) <u>R. Devillac</u>							
22a. (BURIAL) CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>5-5-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Island Creek</u>		22d. LOCATION (City, town, or county) (State) <u>Mutual Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>P. E. Sewell</u>				ADDRESS <u>Prima Frederick</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 7 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

05418

5224 CERTIFICATE OF DEATH

Page One

<p>1. NAME OF DECEASED [Name of deceased]</p>		<p>2. SEX [Male/Female]</p>	
<p>3. DATE OF BIRTH [Date of birth]</p>		<p>4. PLACE OF BIRTH [Place of birth]</p>	
<p>5. DATE OF DEATH [Date of death]</p>		<p>6. PLACE OF DEATH [Place of death]</p>	
<p>7. CAUSE OF DEATH [Cause of death]</p>		<p>8. MANNER OF DEATH [Manner of death]</p>	
<p>9. SIGNATURE OF PHYSICIAN [Signature]</p>		<p>10. SIGNATURE OF REGISTRAR [Signature]</p>	
<p>11. SIGNATURE OF WITNESS [Signature]</p>		<p>12. SIGNATURE OF DECEASED [Signature]</p>	
<p>13. SIGNATURE OF NEXT OF KIN [Signature]</p>		<p>14. SIGNATURE OF BURIAL SOCIETY [Signature]</p>	
<p>15. SIGNATURE OF FUNERAL HOME [Signature]</p>		<p>16. SIGNATURE OF CEMETERY [Signature]</p>	
<p>17. SIGNATURE OF CHURCH [Signature]</p>		<p>18. SIGNATURE OF OTHER [Signature]</p>	
<p>19. SIGNATURE OF DECEASED [Signature]</p>		<p>20. SIGNATURE OF DECEASED [Signature]</p>	
<p>21. SIGNATURE OF DECEASED [Signature]</p>		<p>22. SIGNATURE OF DECEASED [Signature]</p>	
<p>23. SIGNATURE OF DECEASED [Signature]</p>		<p>24. SIGNATURE OF DECEASED [Signature]</p>	
<p>25. SIGNATURE OF DECEASED [Signature]</p>		<p>26. SIGNATURE OF DECEASED [Signature]</p>	
<p>27. SIGNATURE OF DECEASED [Signature]</p>		<p>28. SIGNATURE OF DECEASED [Signature]</p>	
<p>29. SIGNATURE OF DECEASED [Signature]</p>		<p>30. SIGNATURE OF DECEASED [Signature]</p>	
<p>31. SIGNATURE OF DECEASED [Signature]</p>		<p>32. SIGNATURE OF DECEASED [Signature]</p>	
<p>33. SIGNATURE OF DECEASED [Signature]</p>		<p>34. SIGNATURE OF DECEASED [Signature]</p>	
<p>35. SIGNATURE OF DECEASED [Signature]</p>		<p>36. SIGNATURE OF DECEASED [Signature]</p>	
<p>37. SIGNATURE OF DECEASED [Signature]</p>		<p>38. SIGNATURE OF DECEASED [Signature]</p>	
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<p>41. SIGNATURE OF DECEASED [Signature]</p>		<p>42. SIGNATURE OF DECEASED [Signature]</p>	
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<p>45. SIGNATURE OF DECEASED [Signature]</p>		<p>46. SIGNATURE OF DECEASED [Signature]</p>	
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<p>77. SIGNATURE OF DECEASED [Signature]</p>		<p>78. SIGNATURE OF DECEASED [Signature]</p>	
<p>79. SIGNATURE OF DECEASED [Signature]</p>		<p>80. SIGNATURE OF DECEASED [Signature]</p>	
<p>81. SIGNATURE OF DECEASED [Signature]</p>		<p>82. SIGNATURE OF DECEASED [Signature]</p>	
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<p>93. SIGNATURE OF DECEASED [Signature]</p>		<p>94. SIGNATURE OF DECEASED [Signature]</p>	
<p>95. SIGNATURE OF DECEASED [Signature]</p>		<p>96. SIGNATURE OF DECEASED [Signature]</p>	
<p>97. SIGNATURE OF DECEASED [Signature]</p>		<p>98. SIGNATURE OF DECEASED [Signature]</p>	
<p>99. SIGNATURE OF DECEASED [Signature]</p>		<p>100. SIGNATURE OF DECEASED [Signature]</p>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

5425

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05416

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cabot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Cabot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince George's</u>		c. LENGTH OF STAY IN 1b <u>10 mo.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Cabot C.H.</u>		d. STREET ADDRESS <u>St. Leonard</u>	
3. NAME OF DECEASED (Type or print) <u>Richard</u> First <u>Gutmann</u> Middle <u>Gutmann</u> Last		4. DATE OF DEATH <u>5</u> Month <u>16</u> Day <u>19</u> Year <u>59</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/6/186</u>
9. AGE (In years <u>73</u> yrs.)		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Baker</u>	
11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Lawrence Gutmann</u>		14. MOTHER'S MAIDEN NAME <u>Frieda Hecken</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>Wm. Mary Gutmann</u> Address <u>St. Leonard</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 962X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Renal Disease</u> DUE TO <u>Fracture neck about 1 yr ago</u> (c) <u>Fracture neck about 1 yr ago and has been without</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs</u> <u>1 yr</u> <u>1 yr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture neck about 1 yr ago and has been without</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE EXTERNAL INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>May 5</u> Hour <u>11</u> a. m. <u>30</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) <u>Home</u>		20f. (City or town) <u>St. Leonard</u> (County) <u>Cabot</u> (State) <u>MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>H. W. Ward</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>H. W. WARD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 19, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Leonard Catholic Cem.</u>		22d. LOCATION (City, town, or county) <u>St. Leonard</u> (State) <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>O. R. Harkness & Son - Mutual, Ind</u>		24a. REC'D BY REGISTRAR <u>May 19 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

5426 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <u>md.</u> c. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hughesville</u> 08X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Calvert County Hospital</u>		d. STREET ADDRESS <u></u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>HERMAN ORDMAN HUGHES</u> First Middle Last		4. DATE OF DEATH <u>May 5</u> 19 <u>59</u> Month Day Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 31, 1883</u>
9. AGE (In years last birthday) <u>75</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Eugene Hughes</u>		14. MOTHER'S MAIDEN NAME <u>Emma Ordeman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u> (If yes, give war or dates of service) <u></u>		16. SOCIAL SECURITY NO. <u></u> 17. INFORMANT Address <u>Mrs. F. D. Chappelle, Hughesville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>aspiration pneumonia</u> 150X DUE TO <u>Carcinoma of Esophagus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 hours</u> <u>8 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>4/27</u> 19 <u>59</u> , to <u>5/5</u> 19 <u>59</u> , that I last saw the deceased alive on <u>5/5</u> 19 <u>59</u> , and that death occurred at <u>2:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Page Jett</u>		ADDRESS (Street, city or town, state) <u>Prince Frederick</u> DATE SIGNED <u>PRINCE FREDERICK</u>	
PHYSICIAN'S NAME (Type) <u>PAGE JETT</u>		<u></u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	22b. DATE THEREOF <u>5/7/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Suitland, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Hines Company</u> ADDRESS <u>2901 14th St. Washington 9,</u>		24. RECEIVED BY REGISTRAR <u>DATE MAY 7 '59</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

100-117

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

CERTIFICATE OF DEATH

Form No. 100-117

1. NAME OF DECEASED [Blank]		2. SEX [Blank]		3. AGE [Blank]		4. DATE OF BIRTH [Blank]		5. PLACE OF BIRTH [Blank]	
6. OCCUPATION [Blank]		7. MARITAL STATUS [Blank]		8. COLOR [Blank]		9. RELIGION [Blank]		10. NATIONALITY [Blank]	
11. DATE OF DEATH [Blank]		12. TIME OF DEATH [Blank]		13. PLACE OF DEATH [Blank]		14. CAUSE OF DEATH [Blank]		15. MANNER OF DEATH [Blank]	
16. SIGNATURE OF DECEASED [Blank]		17. SIGNATURE OF WITNESS [Blank]		18. SIGNATURE OF DECEASED [Blank]		19. SIGNATURE OF WITNESS [Blank]		20. SIGNATURE OF DECEASED [Blank]	
21. SIGNATURE OF DECEASED [Blank]		22. SIGNATURE OF WITNESS [Blank]		23. SIGNATURE OF DECEASED [Blank]		24. SIGNATURE OF WITNESS [Blank]		25. SIGNATURE OF DECEASED [Blank]	
26. SIGNATURE OF DECEASED [Blank]		27. SIGNATURE OF WITNESS [Blank]		28. SIGNATURE OF DECEASED [Blank]		29. SIGNATURE OF WITNESS [Blank]		30. SIGNATURE OF DECEASED [Blank]	
31. SIGNATURE OF DECEASED [Blank]		32. SIGNATURE OF WITNESS [Blank]		33. SIGNATURE OF DECEASED [Blank]		34. SIGNATURE OF WITNESS [Blank]		35. SIGNATURE OF DECEASED [Blank]	
36. SIGNATURE OF DECEASED [Blank]		37. SIGNATURE OF WITNESS [Blank]		38. SIGNATURE OF DECEASED [Blank]		39. SIGNATURE OF WITNESS [Blank]		40. SIGNATURE OF DECEASED [Blank]	
41. SIGNATURE OF DECEASED [Blank]		42. SIGNATURE OF WITNESS [Blank]		43. SIGNATURE OF DECEASED [Blank]		44. SIGNATURE OF WITNESS [Blank]		45. SIGNATURE OF DECEASED [Blank]	
46. SIGNATURE OF DECEASED [Blank]		47. SIGNATURE OF WITNESS [Blank]		48. SIGNATURE OF DECEASED [Blank]		49. SIGNATURE OF WITNESS [Blank]		50. SIGNATURE OF DECEASED [Blank]	
51. SIGNATURE OF DECEASED [Blank]		52. SIGNATURE OF WITNESS [Blank]		53. SIGNATURE OF DECEASED [Blank]		54. SIGNATURE OF WITNESS [Blank]		55. SIGNATURE OF DECEASED [Blank]	
56. SIGNATURE OF DECEASED [Blank]		57. SIGNATURE OF WITNESS [Blank]		58. SIGNATURE OF DECEASED [Blank]		59. SIGNATURE OF WITNESS [Blank]		60. SIGNATURE OF DECEASED [Blank]	
61. SIGNATURE OF DECEASED [Blank]		62. SIGNATURE OF WITNESS [Blank]		63. SIGNATURE OF DECEASED [Blank]		64. SIGNATURE OF WITNESS [Blank]		65. SIGNATURE OF DECEASED [Blank]	
66. SIGNATURE OF DECEASED [Blank]		67. SIGNATURE OF WITNESS [Blank]		68. SIGNATURE OF DECEASED [Blank]		69. SIGNATURE OF WITNESS [Blank]		70. SIGNATURE OF DECEASED [Blank]	
71. SIGNATURE OF DECEASED [Blank]		72. SIGNATURE OF WITNESS [Blank]		73. SIGNATURE OF DECEASED [Blank]		74. SIGNATURE OF WITNESS [Blank]		75. SIGNATURE OF DECEASED [Blank]	
76. SIGNATURE OF DECEASED [Blank]		77. SIGNATURE OF WITNESS [Blank]		78. SIGNATURE OF DECEASED [Blank]		79. SIGNATURE OF WITNESS [Blank]		80. SIGNATURE OF DECEASED [Blank]	
81. SIGNATURE OF DECEASED [Blank]		82. SIGNATURE OF WITNESS [Blank]		83. SIGNATURE OF DECEASED [Blank]		84. SIGNATURE OF WITNESS [Blank]		85. SIGNATURE OF DECEASED [Blank]	
86. SIGNATURE OF DECEASED [Blank]		87. SIGNATURE OF WITNESS [Blank]		88. SIGNATURE OF DECEASED [Blank]		89. SIGNATURE OF WITNESS [Blank]		90. SIGNATURE OF DECEASED [Blank]	
91. SIGNATURE OF DECEASED [Blank]		92. SIGNATURE OF WITNESS [Blank]		93. SIGNATURE OF DECEASED [Blank]		94. SIGNATURE OF WITNESS [Blank]		95. SIGNATURE OF DECEASED [Blank]	
96. SIGNATURE OF DECEASED [Blank]		97. SIGNATURE OF WITNESS [Blank]		98. SIGNATURE OF DECEASED [Blank]		99. SIGNATURE OF WITNESS [Blank]		100. SIGNATURE OF DECEASED [Blank]	



100-117

05418

5427 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Calvert</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Calvert</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>				c. LENGTH OF STAY IN 1b <u>17 hrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Calvert County Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Jones</u>				4. DATE OF DEATH Month Day Year <u>May 4 1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5/3/59</u>	
9. AGE (In years last birthday) <u>17</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>Lloyd Edwin Jones</u>		14. MOTHER'S MAIDEN NAME <u>Carlise Brooks</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>(If yes, give war or dates of service)</u>		17. INFORMANT <u>Carlise Jones, Huntingtown Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>776X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____				20g. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>May 3</u> , 19 <u>59</u> , to <u>May 4</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>May 4</u> , 19 <u>59</u> , and that death occurred at <u>1 P.</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____							
ACTUAL SIGNATURE <u>[Signature]</u> M.D. _____							
PHYSICIAN'S NAME (Type) <u>Dr. George J. Weems</u> <u>Huntingtown Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-5-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Private lot.</u>		22d. LOCATION (City, town, or county) (State) <u>Huntingtown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lloyd E. Jones - Huntingtown Md.</u>				24a. REC'D BY REGISTRAR DATE <u>5/14/59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2064223X-1

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5428

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

05419

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owney Md</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived. If Institution/Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Calvert</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owney Md</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Adie</u> First <u>Kent</u> Middle <u>Kent</u> Last <u>Kent</u>		4. DATE OF DEATH Month <u>5</u> Day <u>13</u> Year <u>1959</u>					
5. SEX <u>7</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 2 1899</u> 60 yrs.	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H W</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Wesley Kent</u>		14. MOTHER'S MAIDEN NAME <u>Mary Kent</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Adie Kent</u> Address <u>Owney Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> <u>782.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Found dead in house</u>						INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u>7</u> m. <u>57</u> p. m. <u>13</u> 19 <u>59</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Owney Calvert Md</u>		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>H W Ward</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>5/13/59</u>			
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>5-17-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bethel Way of the Cross</u>		22d. LOCATION (City, town, or county) (State) <u>Sunderland Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>P. E. Sewell, Prince Frederick</u>			ADDRESS		24a. REC'D BY REGISTRAR DATE <u>MAY 20 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

5429

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05420

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> <u>6</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Calvert</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lusby MD</u>		c. LENGTH OF STAY IN 1b <u>X</u> <u>Lusby</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>MARTHA ELIZABETH LEQUESNE</u>		d. STREET ADDRESS <u>Lequesne</u>	
3. NAME OF DECEASED (Type or print) <u>Elizabeth</u> First Middle Last		4. DATE OF DEATH <u>5</u> Month <u>14</u> Day <u>1959</u> Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/8/71</u>
9. AGE (In years <u>87</u> yrs. <u>14</u> Months <u>19</u> Days <u>59</u> Min.)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Church Work</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTH PLACE (State or foreign country) <u>Iowa</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>Joseph Athanasios</u>	
14. MOTHER'S MAIDEN NAME <u>Mentha Fisher</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT <u>Hospital Chart</u> Address <u>8 W McFadden</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>904.0</u> DUE TO <u>Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Fall 4/8/59</u> (c) <u>Age</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Had been doing OK until 5/15/59. Vandy & discharge</u>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u>Fell at home and was found 3 hrs later</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>3</u> p. m. <u>4/8/59</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. City or town (County) (State) <u>Lusby Calvert MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>H W Ward</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>H. W. WARD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>May 16, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>MIDDLEHAM CHAPEL</u>		22d. LOCATION (City, town, or county) (State) <u>LUSBY - CALVERT CO - MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. O. Harkness & Son - Mutual, Ind</u>		24a. REC'D BY REGISTRAR <u>DATE MAY 18 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Anthony S. Kraus</u>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1932

Form with multiple sections for medical examination, including fields for name, age, sex, race, date of death, place of death, and cause of death. The form is divided into several horizontal sections with various labels and checkboxes.

NAME: _____

AGE: _____

SEX: _____

RACE: _____

DATE OF DEATH: _____

PLACE OF DEATH: _____

CAUSE OF DEATH: _____

... (other fields) ...

RECEIVED
JAN 11 1932
BALTIMORE

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 3 Film G242 5-18-59 et

Reg. Dist. No.

05421

5430

1. PLACE OF DEATH a. COUNTY <u>Cabot</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Fredrick</u> c. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Cabot Co. Nursing Home</u>		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>3Y01-4</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balti City</u> d. STREET ADDRESS <u>1100 Forrest Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>John Dean</u> First Middle <u>Riddleberger</u> DATE OF DEATH <u>5</u> Month <u>12</u> Day <u>1959</u>		4. SEX <u>7</u> 5. COLOR OF RACE <u>W</u> 6. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 7. DATE OF BIRTH <u>Oct 13, 1877</u> 8. AGE (In years (by birthday) yrs. <u>81</u> IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HW</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u> 11. BIRTHPLACE (State or foreign country) <u>Martinsburg, W. Va.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Charles W. Sheetz</u> 14. MOTHER'S MAIDEN NAME <u>Lucinda (unknown)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> 16. SOCIAL SECURITY NO. <u>(If yes, give war or dates of service)</u>		17. INFORMANT <u>Thomas Riddleberger, 1100 Forrest Street</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary embolism</u> 467.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Subcutaneous hemorrhages</u> DUE TO (c) <u>Was gay to bathroom and fell dead in floor</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 min</u> <u>10 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Was gay to bathroom and fell dead in floor</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year <u>12/5/59</u> 20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u> 20f. (City or town) <u>Prince Fredrick</u> (County) <u>Cabot</u> (State) <u>MD</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>HW Ward</u> EXAMINER'S NAME (Type)		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u> 22b. DATE THEREOF <u>5-14-59</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Green Hill Cemetery</u> 22d. LOCATION (City, town, or county) (State) <u>Martinsburg, W. Va.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook, Inc., 1217 St. Paul Street</u> ADDRESS		24a. REC'D BY REGISTRAR <u>MAY 14 '59</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5431

CERTIFICATE OF DEATH

05422

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Calvert</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Calvert County Hospital</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St. Leonard,</u>	
		f. d. STREET ADDRESS	
		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Webster</u> Last		4. DATE OF DEATH Month <u>May</u> Day <u>20</u> Year <u>19 59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>September 23, 1875</u>
9. AGE (In years last birthday) <u>83</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED MACHINIST</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. GOV'T.</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Daniel Webster</u>		14. MOTHER'S MAIDEN NAME <u>Isabella Webster</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>----</u>	
17. INFORMANT <u>Margaret Webster, St. Leonard, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5/12</u> , 19 <u>59</u> , to <u>5/20</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>May 20</u> , 19 <u>59</u> , and that death occurred at <u>12:00</u> P. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u> M.D.		ADDRESS (Street, city or town, state) <u>St. Leonard, Md.</u> DATE SIGNED <u>5/20</u>	
PHYSICIAN'S NAME (Type) <u>Dr. Roberto de Villarreal</u>		<u>St. Leonard, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5-23-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Seagrave-Washington Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Hyattsville Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Francis Collins</u>		ADDRESS <u>3821-14th St. N. W.</u>	
24a. REC'D BY REGISTRAR <u>MAY 25 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	

66433

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

CERTIFICATE OF DEATH

NAME OF DECEASED ROBERT J. ROBERTS		SEX MALE		AGE 45	
DATE OF DEATH JANUARY 15, 1943		TIME OF DEATH 10:30 A.M.		PLACE OF DEATH HOME	
CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL		PLACE OF BIRTH BALTIMORE, MARYLAND	
OCCASION OF DEATH Sudden		PREVIOUS ILLNESS None		OCCUPATION None	
SIGNATURE OF DECEASED (None)		SIGNATURE OF NEXT OF KIN (None)		SIGNATURE OF PHYSICIAN (None)	
SIGNATURE OF REGISTRAR (None)		SIGNATURE OF CLERK (None)		SIGNATURE OF JURY (None)	